Health Reform Policy Options

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KHPA Board Meeting

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PROMOTING PERSONAL RESPONSIBILITY (P1)

Background Information

One of the three KHPA goals for health reform in Kansas is promoting personal responsibility for health. Underlying this goal is the need for fundamental health system change to facilitate a person's active engagement in maintaining and improving his/her health regardless of age or health status. Achieving optimal health/wellness requires that individuals have greater access to health promotion/wellness interventions, useful health information, and shared financial responsibility for their health care expenditures.

> Improved health behaviors: Policy options designed to increase Kansans' accessibility to health promotion/wellness interventions in schools, the workplace, and in families and communities are described under the second KHPA Health Reform goal of paying for prevention and promoting medical homes.
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> Informed use of health care services: Policy options designed to improve the informed use of health care services include (1) a focus on improving health literacy, and (2) expanding access to consumers regarding health care services, cost, and quality.
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> Shared financial responsibility: Policy options consistent with shared financial responsibility for consumers, providers, purchasers, and government are included under the providing and protecting affordable health insurance.

Background on Health Literacy[1]:

Health literacy is defined in *Health People 2010* as: "The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions". According to the American Medical Association, poor health literacy is "a stronger predictor of a person's health than age, income, employment status, education level, and race" (Report on the Council of Scientific Affairs, Ad Hoc Committee on Health Literacy for the Council on Scientific Affairs, American Medical Association, *JAMA*, Feb 10, 1999). In *Health Literacy: A Prescription to End Confusion*, the Institute of Medicine reports that ninety million people in the United States, nearly half the population, have difficulty understanding and using health information. As a result, patients often take medicines on erratic schedules, miss follow-up appointments, and do not understand instructions like "take on an empty stomach".

Health literacy varies by context and setting and is not necessarily related to years of education or general reading ability. A person who functions adequately at home or work

[1] Excerpts from National Network of Libraries of Medicine; http://nnlm.gov/outreach/consumer/hlthlit.html#A1

may have marginal or inadequate literacy in a health care environment. With the move towards a more "consumer-centric" health care system as part of an overall effort to improve the quality of health care and to reduce health care costs, individuals need to take an even more active role in health care related decisions. To accomplish this people need strong health information skills.

Background on the Consumer Health and Transparency[2]:

Consumers deserve to know the quality and cost of their health care. For every other purchase that they make, consumers can easily get information about price and quality. When consumers have this information they can make better decisions. Consumers should share in the savings, in the form of lower premiums and more effective care, when they take an active role in health care decisions.

Health care transparency provides consumers with the information necessary, and the incentive, to choose health care providers based on value. Providing reliable cost and quality information empowers consumer choice. Consumer choice creates incentives at all levels, and motivates the entire system to provide better care for less money. Improvements will come as providers can see how their practice compares to others. Transparency is a broad-scale initiative enabling consumers to compare the quality and price of health care services, so they can make informed choices among doctors and hospitals. A Kansas Consumer Health Care Transparency Project is currently underway which will begin to collect and make available existing health and health care data resources to the Kansas consumer. This initiative is further described under the policy option that seeks to implement the next phase of the project.

Policy Options: Two policy options designed to promote the informed use of health care services by Kansans associated are described in more detail in separate documents:

- (1) Improved health literacy
- (2) Consumer health transparency project (phase II)

[2] Excerpts from Value Driven Health Care Home Initiative; US Health and Human Services Secretary Michael Leavitt; http://www.hhs.gov/valuedriven/index.html

P1 (1) Informed Use of Health Services: Transparency for Consumers: Health Care Cost and Quality Transparency Project

Policy: Support the second phase of the Kansas Consumer Health Care Transparency Project which will begin to collect and make available existing health and health care data resources to the Kansas consumer.

Background:
In FY2008 KHPA approved a two phase health information transparency initiative for consumers. In Phase I the State Library of Kansas is working with other libraries to create a portal of existing health and health care resources for Kansas consumers. The Health Transparency portal will be marketed to all public libraries in Kansas as "the icon for health care" and training in the use of the portal will commence after January 1, 2008. The development of the portal has begun and will be functionally implemented by January 15, 2008 and fully implemented by June 2008. Simultaneously the NLM/GoLocal development is proceeding which brings information about local health care services and support groups to Kansas consumers and will be integrated with the portal. A health information curriculum will be established to educate Kansans about the use of health information and available health resources.

In Phase II of the "Health Transparency Project Kansas specific health quality and cost measures recommended to the KHPA Board by the Data Consortium (which consists of health care stakeholders in Kansas) will be developed and made available to consumers through the Health Transparency Portal, allowing consumers to compare cost and quality of health providers and plans.

Kansas-Specific Data:
There are 327 public libraries located across the state of Kansas. The public library system is regionalized into seven districts; Central, North Central, Northeast, Northwest, South Central, Southeast, and Southwest. The public libraries have long served as a focal point in the community for information exchange. The GoLocal feature of this project will localize resources pertinent to the seven library districts.

Population Served:
The entire population of the state (2,764,075) has access to the public libraries in their community or communities nearby.

Costs:
$200,000 is needed for implementation of Phase II of the Transparency project. These funds will be utilized to continue the employment of the librarian dedicated to the project, maintain the authentication software allowing Kansans to access copy-written materials,

provide grants to local libraries, market the program, and integrate the health quality and cost data.

Considerations:
In FY2008 KHPA board approved the two phase health information transparency initiative for consumers. Phase I activities are have been initiated and training in the use of the portal will begin in January, 2008. Phase II planned activities are essential for achievement of the goal of assisting Kansans to make wise health purchasing decisions by providing them access to quality and cost data.

Stakeholder Input:
Multiple members of the advisory councils commented upon the need for quality health information.

P1 (2) Promoting Informed Use of Health Services: Improving Health Literacy

Policy: Establish a pilot program to provide payment incentives to Medicaid/Healthwave providers who adopt health literacy enhancement initiatives in their practice settings.

Background:
An informed purchase of health care services requires health literacy by the consumer. Health literacy is the skill set required for an individual to gain access to and understand and use information in ways which promote and maintain good health. The health care system needs to improve people's access to health information and their capacity to use it effectively.

Nearly half of all adults have a health literacy problem. People with limited literacy skills have less knowledge about and poorer adherence to medication and self-care regimens for certain chronic conditions; have less knowledge and less likelihood of getting specific preventive tests and exams; have poorer self-reported health and poorer health outcomes; and have increased hospitalizations and costs.

A large gap exists between the health literacy level of people and the level of health information produced by the health industry, creating a situation where many consumers cannot understand the health information they receive from providers. In 1998, inadequate health literacy cost the US health system an estimated $30-73 billion. A small number of states have specific projects focused on health literacy but these initiatives are in their infancy and much more needs to be done if persons are to achieve optimal health particularly if they are living with chronic disease.

Kansas-Specific Data: A 2007 survey by Health Literacy Innovations of Medicaid agencies indicated that in Kansas was among 56% of states who had set readability guidelines for their Medicaid materials at a 6th grade reading level.

Population Served: Medicaid/Healthwave enrollees who are under the care of providers adopting the health literacy enhancement strategies.

Costs:
$250,000 to establish a pilot program that provides financial incentives to Medicaid/Healthwave providers who adopt health literacy enhancement initiatives.

Considerations:
- A 2004 Institute of Medicine study examined the body of knowledge related to health literacy and recommended actions to promote a health-literate society.
- The 2002 Council of State Governments (CSG) comprehensive study of health literacy identified "best practice" models including the development of adult and school-age health literacy toolkits and the appointment of a health literacy task force.
- The Kansas chapter of the American Academy of Pediatrics is focusing on Health Literacy and has received a $1,000,000 challenge grant from KHF for the statewide early literacy program "Turn a Page. Touch a Mind".
- The Kansas City Missouri Health Department is developing a health literacy initiative targeted to grades kindergarten through third grade focused on prevention and health issues.

Stakeholder Input:
Multiple Advisory Council members mentioned the health literacy issue and the need for useable health information.

PROMOTING MEDICAL HOMES AND PAYING FOR PREVENTION (P2)

P2: Promoting Medical Homes

Background of the Medical Home Concept[1]

Many Americans may not be familiar with the term "medical home," however, they know when they don't have one—that is, a primary care practice that provides them with accessible, continuous, and coordinated care. A medical home is more than just a place; it is a comprehensive approach to providing care. The idea of a medical home is 180 degrees from an emergency room, urgent care facility, or walk-in clinic. In medical home practices, patients develop relationships with their providers and work with them to maintain healthy lifestyles and coordinate preventive and ongoing health services. In this sense, medical homes are the foundation of patient-centered care, designated by the Institute of Medicine as one of the six aims for the health care system, and defined as care that is respectful of, and responsive to, individual patient preferences, needs, and values.[3]

The concept of a medical home began with pediatricians, who see children frequently during their early years and thus have opportunities to provide comprehensive care, including developmental and behavioral services. In 1977, the American Academy of

[3] Excerpts from "Schoenbaum, S., Davis, K., Abram, M. No Place Like Home. *Commonwealth Fund.* Dec. 19, 2006"

Pediatrics adopted a policy statement which declared that "quality medical care is also best provided when all of the child's medical data are together in one place, (a medical home) readily accessible to the responsible physician or physicians." The Academy has fleshed out this concept over the years. In 2002, it described the concrete attributes of a medical home, for example defining "accessible" care as care that is physically and financially within reach of patients, but which is also facilitated by effective patient–provider communication. "Comprehensive" care, they maintained, should extend beyond basic medical care to include educational, developmental, psychosocial, and other individual needs[1].

In its 2002 policy statement, the AAP expanded the medical home concept to include these operational characteristics: accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care. The American Academy of Family Physicians (AAFP) and the American College of Physicians (ACP) have since developed their own models for improving patient care called the “medical home” (AAFP, 2004) or “advanced medical home” (ACP, 2006). The “Joint Principles for a Medical Home” were established by the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the American College of Physicians (ACP), the American Osteopathic Association (AOA) in Feb. 2007

Many experts argue that medical homes are important for all patients, not just children and adolescents. As part of broader quality improvement efforts, medical homes could ensure the provision of appropriate preventive services, help patients manage their chronic conditions, and reduce spending on emergency or other acute care. Nurses would play central roles, working with primary care physicians to develop disease management programs for patients with chronic illness and provide support for all patients in their efforts to live healthy, productive lives.

Yet, there are significant challenges to realizing the promise of medical homes. Many of the services called for in true medical homes, such as linking patients with needed community services, providing consultations via e-mails, and consulting or coordinating care with other physicians, are not usually paid for directly by insurers. And, for a variety of reasons including lack of insurance coverage, 13 percent of Americans did not have a usual source of care in 2005. Frequent job changes or relocations also contribute to people moving in and out of different practices. Studies show that those without a primary care provider are more likely to have unmet needs for care, more hospitalizations, and higher costs of care, and they are less likely to keep doctor appointments and receive preventive care services.

What's more, the number of American medical graduates entering primary care fields—particularly family medicine and general internal medicine—has dropped precipitously. Creating medical homes would require changes in training. Learning to coordinate care and manage a practice are not prominent subjects in physician training. Nurses and physicians' assistants might extend the nation's capacity to deliver primary care services, but face similar challenges with respect to reimbursement.

Policy Options: A number of policy options associated with the development of person/patient centered medical homes in Kansas are described in more detail in separate documents:

- (1) Defining a Medical Home in statute, and requiring that Medicaid/Healthwave beneficiaries select a medical home for primary care services
- (2) Development and promotion of a statewide Community Health Record for Medicaid/Healthwave and the State Employee Health Plan (SEHP)
- (3) Increased Medicaid/Healthwave reimbursement for primary care services consistent with a medical home and "value based health care"
- (4) Adopt recommendations from Advanced ID Card Project for Medicaid/Healthwave beneficiaries and for the State Employee Health Plan (SEHP)

P2: Promoting Medical Homes (1): Defining a Medical Home in statute

Policy: Develop a statutory definition of a medical home for state-funded health programs (Medicaid/Healthwave, and the State-Employee Health Plan).

Background: One of the components of Kansas health reform is to promote a person/patient centered medical home as a way to improve the quality of primary health care, promote improved health status, and ultimately help to control the rising costs of health care. As defined by the American Academy of Pediatrics, "A medical home is not a building, house, or hospital, but rather an approach to providing comprehensive primary care. A medical home is defined as primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective."

Promoting the development and use of medical home practices will help to organize health care services through a medical home model with the goal of improving health outcomes and containing health care costs. States such as Colorado, Washington, Missouri and Louisiana, advancing the medical home model and passing legislation to organize Medicaid programs around the medical home concept. North Carolina has used existing legislative authority to extend the medical home concept to its Medicaid and SCHIP populations. A number of states have defined a medical home in statute, such as Louisiana, Colorado and Massachusetts.

> **Example: Colorado Medical Home statutory definition (for demonstration purposes only; Kansas stakeholders and the KHPA should develop a Kansas specific definition)**
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> **25.5-1-123. Medical homes for children - legislative declaration - duties of the department - reporting requirements.** (1) THE GENERAL ASSEMBLY HEREBY FINDS AND DECLARES THAT:

(a) THE BEST MEDICAL CARE FOR INFANTS, CHILDREN, AND ADOLESCENTS IS PROVIDED THROUGH A MEDICAL HOME, AS DEFINED IN SECTION 25.5-1-103, AND THAT IS CONSISTENT WITH THE JOINT PRINCIPLES OF A PATIENT-CENTERED MEDICAL HOME. THOSE PRINCIPLES SHALL INCLUDE A WHOLE PERSON ORIENTATION, CARE THAT IS COORDINATED AND INTEGRATED ACROSS ALL ELEMENTS OF THE COMPLEX HEALTH CARE SYSTEM AND THE PATIENT'S COMMUNITY, AND CARE THAT PROVIDES FOR QUALITY AND SAFETY OF THE PATIENT WHERE QUALIFIED HEALTH CARE PRACTITIONERS PROVIDE PRIMARY CARE AND HELP MANAGE AND FACILITATE ALL ASPECTS OF MEDICAL CARE;
(b) INFANTS, CHILDREN, AND ADOLESCENTS AND THEIR FAMILIES WORK BEST WITH A HEALTH CARE PRACTITIONER WHO KNOWS THE FAMILYAND WHO DEVELOPS A PARTNERSHIP OF MUTUAL RESPONSIBILITY AND TRUST;
(c) MEDICAL CARE PROVIDED THROUGH EMERGENCY DEPARTMENTS, WALK-IN CLINICS, AND OTHER URGENT-CARE FACILITIES IS OFTEN MORE COSTLY AND LESS EFFECTIVE THAN CARE GIVEN BY A PHYSICIAN WITH PRIOR KNOWLEDGE OF THE CHILD AND HIS OR HER FAMILY; AND
(d) THE STATE DEPARTMENT SHOULD STRIVE TO FIND A MEDICAL HOME FOR EACH CHILD RECEIVING SERVICES THROUGH THE STATE MEDICAL ASSISTANCE PROGRAM, ARTICLES 4, 5, AND 6 OF THIS TITLE, OR THE CHILDREN'S BASIC HEALTH PLAN, ARTICLE 8 OF THIS TITLE.
(2) ON OR BEFORE JULY 1, 2008, THE STATE DEPARTMENT, IN CONJUNCTION WITH THE COLORADO MEDICAL HOME INITIATIVE IN THE DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT, SHALL DEVELOP SYSTEMS AND STANDARDS TO MAXIMIZE THE NUMBER OF CHILDREN ENROLLED IN THE STATE MEDICAL ASSISTANCE PROGRAM OR THE CHILDREN'S BASIC HEALTH PLAN WHO HAVE A MEDICAL HOME. THE SYSTEMS AND STANDARDS DEVELOPED SHALL INCLUDE, BUT NEED NOT BE LIMITED TO, WAYS TO ENSURE THAT A MEDICAL HOME SHALL OFFER FAMILY-CENTERED, COMPASSIONATE, CULTURALLY EFFECTIVE CARE AND SENSITIVE, RESPECTFUL COMMUNICATION TO A CHILD AND HIS OR HER FAMILY.
(3) ON OR BEFORE JANUARY 30, 2008, AND EVERY JANUARY 30 THEREAFTER, THE STATE DEPARTMENT SHALL REPORT TO THE HEALTH AND HUMAN SERVICES COMMITTEES OF THE HOUSE OF REPRESENTATIVES AND THE SENATE, OR ANY SUCCESSOR COMMITTEES, ON PROGRESS MADE TOWARD MAXIMIZING THE NUMBER OF CHILDREN WITH A MEDICAL HOME WHO ARE ENROLLED IN THE STATE MEDICAL ASSISTANCE PROGRAM OR THE CHILDREN'S
BASIC HEALTH PLAN.

Cost Estimate: The planning process should incur minimal costs to the KHPA. Costs associated with reimbursement for the medical home model are not considered here.

Population Served: All beneficiaries of state-funded health care plans (Medicaid and the State Employee Health Plan), as well as Kansas health care providers.

Considerations:

- The designation of the medical home is a cornerstone of support for other areas of the KHPA preventive health agenda. Defining in statute the meaning of a medical home in Kansas will provide the framework for further development and implementation of a medical home model.
- In order to determine the appropriate definition of a medical home for state-funded health programs (Medicaid/Healthwave, and the State-Employee Health Plan), a process should be developed to include stakeholder input.
- In conjunction with other state agencies and with stakeholder input, KHPA will draft measures for designating specific health care provider practices and settings as primary care medical; Kansas specific data will be collected and evaluated.
- Expanding the patient/person center medical home will require partnership with mid-level practitioners and safety net clinics, which are critical to serving the needs of rural communities and underserved areas in Kansas.
- The medical home in Kansas should recognize the importance of mental health services and the relationship between physical and mental health. In addition, the addressing appropriate services and continuum of care over the life span is critical to the medical home, which should include a focus on improvement on end-of-life care.

Stakeholder input: The support of a medical home has been endorsed by the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the American College of Physicians (ACP), and the American Osteopathic Association (AOA). The Kansas chapters of these organizations are also supportive of a medical home model.

As part of the stakeholder process moving forward, additional stakeholder feedback should be solicited from various health care practitioners (such as nurse practitioners and physician assistants, rural health clinics and safety net health care clinics, and organizations with specific expertise in various aspects of the continuum of care).

P2 Promoting Medical Homes (2): Increase Medicaid provider reimbursement

Policy: Analyze and increase specific reimbursement for primary care services consistent with a medical home model and "value-based health care purchasing" for the Kansas Medicaid/Healthwave program.

Background: One of the components of Kansas health reform is to promote a person/patient centered medical home as a way to improve the quality of primary health

care, promote improved health status, and ultimately help to control the rising costs of health care. As defined by the American Academy of Pediatrics, "A medical home is not a building, house, or hospital, but rather an approach to providing comprehensive primary care. A medical home is defined as primary care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective."

The concept of value-based health care purchasing is that purchasers should focus on outcomes, cost and quality of health care through the informed use of health care services. In Kansas, value based purchasing can focus on incentives for health services delivered through a primary care medical home, thus reducing inappropriate care. The health care system and its' patterns of reimbursement currently serve as disincentives for providers to take time to provide those preventive services not associated with a technical procedure. Even those technical procedures associated with prevention activities are often not paid for at the optimal rates. Health care reform should include a commitment to analyze the reimbursement rates of health providers serving beneficiaries of state-funded health plans for a wide range of screening activities and preventive care.

In Kansas, value based purchasing can focus on incentives for health services delivered through a primary care medical home, thus reducing inappropriate care and their commensurate costs. This year, the State Employee Health Plan (SEHP) is moving toward value based purchasing with a focus on "first dollar coverage" for preventive services and annual wellness exams, as well as a significant investment in health promotion through incentives aimed at self-engagement in health and wellness activities. Additional improvements in the SEHP will include incentives for providers to deliver health services consistent with a primary care medical home.

Population Served: Beneficiaries and health care providers in the Kansas Medicaid/Healthwave program.

Cost Estimate: Costs will depend upon the number of Medicaid CPT codes that are increased, assuming that the reimbursement rate will mirror Medicare CPT code reimbursement.

Considerations:

- Increased reimbursement for primary care preventive services is key. On average, physicians serving Medicaid beneficiaries are reimbursed at 83% of the maximum allowable Medicare rate for most preventive services. This proposal would include a review of reimbursement for primary care preventive services including well-child visits, immunizations, disease screening, and other clinical procedures linked to Current Procedural Terminology (CPT) and Health Care Procedural Services (HPCS) codes. Providing maximal reimbursement for current codes, and recognizing and reimbursing new and needed preventive service codes, will drive health care professionals to provide more preventive care.
- This year, the State Employee Health Plan (SEHP) is moving toward value based purchasing with a focus on "first dollar coverage" for preventive services and

annual wellness exams, as well as a significant investment in health promotion through incentives aimed at self-engagement in health and wellness activities (for both employees and their dependents). This includes reimbursement for telemedicine to increase access to care for rural Kansans. Additional improvements in the SEHP for next year will include incentives for providers to deliver health services consistent with a primary care medical home.

- The KHPA has the ability to determine code recognition and reimbursement patterns within state-funded health care programs. Instituting similar plans within private health care plans will be a result of voluntary action. Nonetheless, private health care plans often follow government-led efforts in the nature and scope of benefit design. In the larger perspective of advocating for the health of the state, it is appropriate for the Authority to express an opinion on this issue.

Stakeholder Input: The support of a medical home has been endorsed by the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the American College of Physicians (ACP), and the American Osteopathic Association (AOA). The Kansas chapters of these organizations are also supportive of a medical home model that better reimburses for the cost of primary and preventive care.

P2. Promoting Medical Homes (3): Implement Statewide Community Health Record

Policy: Design a statewide community health record to promote the coordination and exchange of health information for state funded health programs (Medicaid/Healthwave, and the State-Employee Health Plan).

Background*:* Improving the coordination of health care is a key component of a medical home model and the utilization of health information technology is a primary means to improve coordination. The clinical care of state-funded health plan beneficiaries is fragmented between different providers, clinics, and other health care facilities. This fragmentation leads to discontinuities in care related to lack of effective information exchange. Similar difficulties exist in the transmission of health plan eligibility and benefit information. Promoting the exchange of clinical and fiscal health care information can enhance the process of care. Improving access to personal health information by consumers will help to promote self-management of care and personal responsibility.

Nearly two years ago, the State of Kansas implemented a pilot project to use of a community health record (CHR) to help deliver timely and accurate health information for Medicaid beneficiaries. The state is currently engaging select managed care organizations and an information technology company to deploy CHR technology to Medicaid managed care providers in Sedgwick County. The goal of the CHR is to improve the quality, safety, and cost-effectiveness of the health care delivery system. The CHR also enables KHPA to focus on prevention and the creation of a primary care medical home.

The current CHR pilot project is built on administrative claims data and provides clinicians electronic access to claimed medical visits, procedures, diagnoses, medications, demographics, allergies and sensitivities, immunizations, vital signs, and lead screening and health maintenance data (includes Early and Periodic Screening, Diagnosis and Treatment [EPSDT] status). The record also contains an e-Prescribing component that enhances the clinician's workflow, reduces the risk of medication error caused by inadequate or unavailable patient information, and increases safety and health outcomes associated with prescription generation. This component provides a drug interaction and contraindication tool as well. The prescriber may access formulary information and has the capacity to submit prescriptions to pharmacies electronically. The CHR is also used to link information from beneficiaries participating in the Enhanced Care Management pilot program, which is a community based model for chronic disease management.

A statewide CHR should include as a priority the possibility of a "consumer-centric" view and the use of personal health information by the consumer. As stated by Zoe Baird of the Markle Foundation, "It would seem obvious since health care is all about improving consumer and patient's quality of care and quality of life that we would think of them at the center of any healthcare conversation. In fact, much of the health care IT conversation has been about systems and the players in the health care system and about technology and about standards... in the hands of the consumer and the provider that's serving them, [we} could transform how they're getting health care."

Kansas specific data: In Kansas, approximately 21% of physician offices use electronic clinical information. In the hospital environment, 51% reported access to electronic lab results, 34% reported electronic imaging systems in place, and 24% reported electronic medication administration.

Costs: Range between 2 to 3 million (all funds), depending on the number of additional sites and users included and enhancements made to the system functionality.

Considerations:

- The development of a statewide CHR would leverage the investment and experience gained in Sedgwick County and the pilot CHR project just beginning in Kansas City among employee groups (Care Entrust), which includes Kansas state employees working in the Kansas City region.
- The development and implementation of a statewide CHR would require significant stakeholder input. Accordingly, the KHPA Board should create an "HIT/HIE Advisory Council" to provide ongoing feedback about the development and implementation of a statewide CHR taking into account on the work of the Governor's Health Care Cost Containment Commission, the Health Information Exchange Commission, and the Kansas HISPC (Health Information Security and Privacy Collaboration) project. The HIT/HIE Advisory Council could also provide guidance on the means to provide education and technical support for health care providers interested in integrating health information technology into their practices. Consumer and provider input to this process will be critical.

- A statewide CHR in Kansas should integrate consumer access to allow consumers to review their personal health information (PHI) to further promote personal responsibility and self-management of care. Ensuring consumer privacy and security must be a key consideration in the development of health information exchange; consumers must be given ultimate authority in who is allowed to view their health information.
- As a payer of health care services, the state would leverage its considerable purchasing power to promote the use of health information technology and exchange through a statewide community health record.
- Because a CHR is web-based, health providers are not required to purchase expensive equipment or software technology to utilize a statewide CHR. Providers will require access to the internet and be provided with training on the utilization of the CHR.

Stakeholder Input: Evaluations from health care providers who utilized the CHR in Sedgwick Country were very positive about the utility of the CHR. Significant input and feedback on HIT/HIE has been garnered through the Governor's Health Care Cost Containment Commission, the Health Information Exchange Commission, and the Kansas HISPC (Health Information Security and Privacy Collaboration) project. Additional input specific to a statewide CHR which integrates consumer access could be obtained through the creation of an HIT/HIE Advisory Council.

P2. Promoting Medical Homes (4): Promote Insurance Card Standardization

Policy: Include a standardized format for health insurance cards for Medicaid/Healthwave beneficiaries and for State Employee Health Plan (SEHP) enrollees to decrease administrative costs and improve health care coordination.

Background:
Improving the coordination of health care services is a key component of a medical home. A health insurance ID card is a patient's entry point into the health care system. Presently, ID card technology has advanced to the point that it can be used as a "key" for providers to unlock a patients' financial and insurance eligibility information. KHPA requests moving forward on a project that would transform our current system which includes the utilization of paper ID cards issued monthly, to one that utilizes plastic advanced ID cards that utilize a magnetic stripe or bar code technology. These cards will allow a provider the ability to instantly determine if a member qualifies for a Kansas Medical Assistance Program (KMAP) or future program such as Premium Assistance by swiping or scanning a patient's card.

Kansan's eligible to receive medical benefits through the Medicaid program currently receive a paper identification card to show proof of eligibility to participating providers. In addition to the paper card, beneficiaries enrolled in the HealthWave (SCHIP) program also receive a plastic card, issued by their HMO, to be used in conjunction with the paper ID card. Because this process is administratively complex and expensive, Kansas

Medicaid has been looking at going to plastic cards for some time (1995), but has not done so because of past provider resistance and technical problems.

Recently, (2006) the KHPA funded a project through the Mid-America Coalition on Heath Care to develop a plastic card with advanced ID card technology. In addition to being able to relay a patient's financial and insurance status information instantly, this card technology would also eliminate claim rejection caused by providers inaccurately manually entering patient identification information. The collaboration through this project has helped to prepare stakeholders (see below) for the adoption of the Advanced ID card. The format for the card is being developed using national standards that govern the transmission and receipt of information (C.O.R.E) and that focuses on the specifications of applying ID card technology to patient ID cards (WEDI). The idea of real time eligibility that may some day lead to real time payment and a decrease in claim rejections resonates well with providers.

Population Served:
Kansans who qualify for Medicaid/HealthWave and employees. Kansans participating in the State Employee Health Plan will be affected as KHPA renews contracts with health plans.

Costs: The total costs (all funds) to implement this program will total approximately $171,745.00 in FY2009. $69,659.50 of this cost is SGF.

It is anticipated that the move to the "advanced ID card" will result in cost savings of $210,000 in the first year from the significant reduction in postage, production and materials cost associated with mailing paper cards monthly.

Considerations:

- Each month, EDS produces and mails in excess of 275,000 paper ID cards to eligible beneficiaries. By replacing the monthly mailing of paper ID cards with the more permanent plastic cards, DHPF will realize a cost savings in postage, production and material costs.
- The technology issues regarding this project have been resolved. This is now a systems issue.
- Current investigation indicates most health plans are considering the implementation of advanced ID card technology. However, their willingness ultimately to adopt this technology seems based on four factors: 1) active provider participation in the adoption of new technology, 2) a demonstrated return on investment or cost savings for adopting the technology, 3) the presence of momentum from the market driving the change, and 4) the establishment of national standards to guide the implementation process.
- KHPA moving forward with a project to replace the current program cards with a single plastic card with advanced ID card technology may represent a "tipping point" in the Kansas market toward the widespread adoption of advanced ID card technology.

- KHPA should incorporate the use of advanced ID cards into its RFP process. KHPA should use the RFP process as we renew contracts with insurance plans as a means to ask these plans to adhere to our advanced ID card guidelines.
- The project plan should include the adoption of existing national operational rules and electronic transactions standards (CAQH CORE, and WEDI) rather than creating our own.

Stakeholder Input:
A diverse group of stakeholders representing multiple industries and entities, including; health plans, physicians, medical office managers, practice management software companies, clearinghouse vendors, pharmacies and ancillary providers have been actively meeting and collaborating on this project since September of 2006.

P2. Paying for Prevention: Background on Improving Healthy Behaviors

One of the three major recommendations for health reform in Kansas is to encourage healthy behaviors by individuals in families, communities, schools, workplaces.

Background[4]:

Healthy, productive individuals make our nation strong and vibrant. Advances in medicine contribute to national economic growth by helping Americans recover more quickly from injury and illness, avoid lost or ineffective work time due to flare-ups of chronic conditions, and live longer with higher quality of life.

Progress in preventing and treating disease has added approximately 30 years to Americans' life expectancy since the beginning of the 20th century. For example, over the past 50 years, advances in the treatment of cardiovascular disease alone have added more than three years to the life expectancy of men and women. As Americans live longer, healthier lives, they also are working longer, thus continuing their contributions to the economy. A one year improvement in the life expectancy of the U.S. population translates into an estimated 4 percent increase in gross domestic product (GDP) – an increase currently equal to about $540 billion.

Yet, even as the U.S. health system's ability to prevent and treat disease improves, the prevalence of chronic health problems among working Americans is rising. Individuals, of course, prefer to be healthy and productive rather than sick and unable to work. Yet, illness and chronic conditions can keep people out of work for days or even months at a time or force them to leave the workforce altogether. Inability to work diminishes individuals' quality of life and capacity to provide for themselves and their families. Being unable to work can lead not only to a loss of financial security but also to reduced self esteem and symptoms of depression.

[4] Excerpts from American Hospital Association (October 2007) Healthy People Are Nation Foundation. Original document including citations http://www.aha.org/aha/research-and-trends/AHA-policy-research/2007.html

In addition, lost or unproductive work days pose a significant cost to national and local economies. For example, in Kansas, hypertension, asthma, and diabetes account for an estimated 1.2 million lost work days each year. This is the equivalent of $280 million dollars annually.

The incidence of chronic conditions among the working population is increasing. In 2003, three out of 10 U.S. workers reported having a health problem defined as presence of a chronic condition such as diabetes, arthritis, cancer or heart disease; presence of a disability; or self-reported fair or poor health status. These health conditions lead not only to missed work time
(absenteeism) but also reduced productivity while at work (referred to as "presenteeism"). An estimated 69 million workers took sick days in 2003, amounting to 407 million lost work days. This
translates into $48 billion in wages paid for time not worked because of illness.

A majority of working Americans have at least one absence from work due to illness or go to work sick during the course of a year. A survey of working Americans ages 19 to 64 found that two-thirds missed one or more days of work due to their own health problems or those of a family member in 2003. Additionally, half reported going to work while sick or while worried about the health problems of a family member, and thus were unable to work at full capacity while there.

Focus on Prevention in Kansas[5].

The Kansas health system – like other states across America – has a focus on sick care in expensive settings, with complicated interventions, and an underinvestment in prevention. Although we often talk about the challenges of Kansas' health system in terms of affordable health insurance and mounting health care costs, we rarely mention the issue of health itself. We need to put the issue of our health front and center – and realize that access to health care is a piece of a larger puzzle.

Do Kansans want more health care, or do we want better health? The evidence seems to point to more health care, regardless of outcomes. Indeed, it is predicted that by 2014, health care costs will be 19% of the country's economy and 63% of that growth will be due to a rise in
treated diseases, including obesity, hypertension, and cancer. Health care costs are concentrated in the sick few, with the sickest 10 percent accounting for 64 percent of expenses. And yet, according to the Institute of Medicine, 30 to 40% of every dollar spent in the US on health care is spent on overuse, underuse, misuse, or duplication. Is this the health care that we want more of?
What if Kansans wanted better health?

Many factors impact our health, but our health behaviors are responsible for more than half of our health outcomes. Reforming our health system will require that we reform

[5] Editorial, Marcia Nielsen, Executive Director, KHPA July 17, 2007

ourselves too. In Kansas, 60.5% of adults are overweight or obese, 20.4% percent use tobacco, and almost one fourth of Kansans have high blood pressure.

Policy Options: There are four sets of policy options aimed at paying for prevention and improving health outcomes:

- Improve healthy behaviors in families and communities;
  - Increase tobacco user fee
  - Statewide ban on smoking in public places
  - Partner with community organizations
- Improve healthy behaviors in schools;
  - Include Commissioner of Education on KHPA Board
  - Collect information on health/fitness of Kansas school children
  - Promote healthy food choices in schools
  - Increase Physical Education
- Improve healthy behaviors in the workplace.
  - Wellness grant program for small businesses
  - Healthier food options for state employees
- Additional prevention policies
  - Provide dental care for pregnant women on Medicaid
  - Improve tobacco cessation within Medicaid
  - Expand cancer screenings

P2: Improve Healthy Behaviors in Families and Communities (1): Increase Tobacco User Fee

Policy: Institute an increase in the tobacco user fee. It is proposed that the current excise tax on cigarettes be raised 50 cents per pack and an excise tax be imposed on all smokeless tobacco products.

Background: The burden of tobacco use in Kansas is great. Each year, tobacco causes over 4,000 Kansas deaths, and generates nearly $930 million dollars in health care costs ($196 million within the Medicaid program alone). Policy research has shown that raising the cost of tobacco products is an effective means to decrease the rates of tobacco use. A 10% increase in the price of a pack of cigarettes is associated with a 4% drop in tobacco use (in real terms, an increase of 50 cents per pack of cigarettes may result in 20,000 of the current 400,000 adult smokers in Kansas quitting). The effect is even more pronounced among price-sensitive teens, where a similar price rise results in a 7% reduction in smoking rates.

Fifty percent of tobacco smokers begin their tobacco use before the age of 14. Not only do the habits of adults begin in childhood but tobacco also serves as a gateway to other substance use among youth. Children and adolescents consume more than one billion packs of cigarettes a year. An increase in the excise tax on tobacco products has been one of the most effective ways to discourage youth from starting to smoke. Such a policy

not only serves as an effective deterrent to tobacco use but as an acknowledgement of the health costs that all Kansans incur as a result of usage.

Tobacco use is the leading cause of preventable deaths and health care costs. Increasing levels of imposed tobacco user fees have been demonstrated to decrease smoking rates, resulting in long-term savings in lives and costs. At the end of 2005, the average state excise tax on cigarettes was 92.2 cents per pack and by early 2007 that figure had risen to about $1.03 per pack. Currently the excise tax on a pack of cigarettes in Kansas is 79 cents a pack. An increased excise tax on all tobacco products would both reduce the number of youth who take up smoking and diminish the annual $167 billion health care costs associated with tobacco consumption.

Kansas-Specific Data:

- Kansas last adjusted the state tobacco user fee in 2003 (KDHE).
- 64 percent of Kansas adults support an increase in tobacco user fees to decrease tobacco use regardless of the use of the additional fees (Sunflower Foundation Poll, 2007).
- The current excise tax on cigarettes in Kansas is 79 cents a pack with a national average of $1.03 per pack.
- Kansas ranks 27th in the country in state tax per pack of cigarettes (CDC, Sustaining State Programs for Tobacco Control Data Highlights, 2006).
- 20 percent of Kansas adults smoke (Kansas Behavioral Risk Factor Surveillance System, 2003).
- 21percent of Kansas high school students are current tobacco smokers and 15 percent of male high school students use smokeless tobacco products (CDC Sustaining State Programs for Tobacco Control Data Highlights, 2006).
- 28.6 percent of the adult smokers in Kansas have an income of less than $15,000.
- The annual average of smoking attributable deaths in Kansas is 3,900 (CDC, Sustaining State Programs for Tobacco Control Data Highlights, 2006).

Population Served:

- The entire Kansas population, including the 20 percent who currently smoke, would benefit in a reduction of the $167 billion health care cost associated with tobacco consumption.
- The 21 percent of high school students and 6 percent of middle school students who currently smoke would benefit from having a substantial barrier to smoking.

Costs: The policy initiative incurs no cost to the state. An increase in the tobacco user fee of 50 cents per pack of cigarettes is expected to yield revenues of $51.9 million in tax revenue per year, 7,800 fewer adult smokers, 15,800 fewer youth smokers and a lifetime health savings for individuals currently alive of $318.9 million.

Considerations:

- Tobacco use costs Kansans the equivalent of 86 cents per pack of cigarettes sold to pay for the tobacco-related illness of Medicaid recipients alone. However,

Kansas currently collects only 79 cents per pack of cigarettes in health impact fees to offset this expenditure. (KDHE).

- Tobacco user fees have their greatest impact in the three to four years after enactment. After that time, rates of inflation and modified pricing strategies by tobacco companies establish consumption at a new (albeit lower than before) equilibrium. In order to have the best effect, tobacco user fees must be continually revisited and adapted over time. Kansas last adjusted to state tobacco user fee in 2003.
- A 2007 poll commissioned by the Sunflower Foundation found that 64% of Kansas adults support an increase in tobacco user fees to decrease tobacco use regardless of the destination of the additional revenues.

National Statistics

- Between 1995 and 2000, 17 states raised cigarette taxes by 10 cents or more per pack with each state experiencing a decline in consumption higher than the national average for those years. (National Conference of State Legislatures, 2004).
- A 10 percent increase in the price of a pack of cigarettes is associated with a 4 percent drop in tobacco use. In real terms, an increase of 50 cents per pack of cigarettes may result in 20,000 of the current 400,000 adult smokers in Kansas to quit. A similar price increase results in a 7 percent reduction of teen smokers as well. (KDHE).
- Cigarette taxes are significantly lower in the United States than in other industrialized nations. (National Conference of State Legislatures, 2004).
- The Missouri cigarette tax is the second lowest in the country with a tax of 17 cents a pack with South Carolina being the lowest at .07 cents a pack. (National Conference of State Legislatures).
- New Jersey has the highest tax rate with $2.58 per pack of cigarettes. (KDHE).

Stakeholder Input:

- Provider Advisory Council supports policies that specifically target tobacco use by children.
- The general consensus of the Consumer Advisory Council was support for a general tax increase including a tobacco tax increase.
- Purchaser Advisory Council supports a tobacco tax increase if used as a dedicated and sustainable financing mechanism for health reform.

P2: Improve Healthy Behaviors in Families and Communities (2): Enact a Statewide Ban on Smoking in Public Places

Policy: Enact a statewide smoking ban in public places, coupled with a Governor's Executive Order requiring state agencies to hold meetings in smoke-free facilities will allow Kansans to work and gather without exposure to the negative consequences of secondhand smoke on their health.

Background: This policy option recommends that legislation be enacted that prohibits smoking in all public places. Based on the health impact on cities that have enacted strict clean indoor air laws, a statewide law in Kansas could result in 2,160 fewer heart attacks and $21 million less in associated hospital charges for heart attacks, alone. A recent poll indicated that 73 percent of Kansas adults favor such a state law or local ordinance.

Secondhand smoke is ingested in two ways. The first is through the lit end of the cigarette, the second is by the exhaled smoke of the smoker. Cigarette smoke contains over 4,000 chemicals and is a known carcinogen. At its most severe impact, secondhand smoke results in 3,000 annual cancer deaths in the United States and 35,000 deaths from heart disease. This statistic represents a stark consequence of secondhand smoke but fails to show the full impact. Exposure to cigarette smoke also results in an increase of asthma attacks, lower respiratory tract infections in children under eighteen months old, coughing, and reduced lung function. Pregnant women are particularly susceptible to having low birth weight babies as a result of secondhand smoke exposure. A 2006 Surgeon General's report notes that, "the scientific evidence indicates there is no risk-free level of exposure to secondhand smoke." The National Institute for Occupational Safety and Health (NIOSH) recommends that second hand smoke be considered as a potential occupational carcinogen.

A reduction in secondhand smoke can be accomplished by banning smoking in public places. The American Heart Association reported on the evidence of this outcome in a study conducted in Helena, Montana. When a clean indoor air policy was enacted, there was an immediate decline of 40 percent in occurrence of heart attacks. When the policy was reversed, the occurrence returned to prior levels.

Kansas-Specific Data:

- In Kansas, 72 percent of the working population is protected by worksite nonsmoking policies. (CDC Sustaining State Programs for Tobacco Control Data Highlights, 2006).
- Smoking is the number one preventable cause of death in Kansas and 83% of Kansas adults believe it is a serious health hazard. (Sunflower Foundation 2007).
- Evidence has shown that statewide smoking bans decrease the smoking rate among active smokers by 10 percent, a potential decrease of 40,000 smokers in Kansas. (KDHE).
- 20 percent of Kansas adults smoke. (Kansas Behavioral Risk Factor Surveillance System, 2003)
- The annual average of smoking attributable deaths in Kansas is 3,900. (CDC, Sustaining State Programs for Tobacco Control Data Highlights, 2006).

Considerations:

- Enactment of smoke free policies at the state level would address the issue of business owners who believe that local control of smoking bans results in an uneven playing field as businesses compete with other jurisdictions that may have no ban in place.

- More than 40 states have imposed restrictions on smoking in public places. (National Conference of State Legislatures 2004).
- Smoking restrictions in workplaces have been shown to decrease smoking prevalence among employees.
- The Surgeon General's 2006 report ends the debate regarding the toxicity of second-hand smoke. The report summarizes the evidence regarding health impact from exposure to the more than 50 carcinogens in second-hand smoke, which results in lung disease, respiratory disease and atherosclerotic disease that leads to heart attack and stroke.
- Secondhand smoke contains at least 250 chemicals known to be toxic, including more than 50 that can cause cancer. (National Toxicology Program, 11th Report on Carcinogens, 2005).
- Approximately 3,000 nonsmokers die nationwide each year of lung cancer from second hand smoke. (California Environmental Protection Agency. Proposed Identification of Environmental Tobacco Smoke as a Toxic Air Contaminant).
- Nonsmokers who are exposed to secondhand smoke at home or work increase their heart disease risk by 25–30 percent and their lung cancer risk by 20–30 percent. (U.S. Department of Health and Human Services. The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General).
- This policy would propose a Governor's Executive Order to require state agency sponsored meetings to be held in smoke-free facilities. This action would serve not only to protect State employees when conducting state business, but would serve as an economic incentive for facilities and cities across the state to adopt smoke-free policies, which would benefit the population at large. The evidence is clear that smoke-free policies protect health without harming business and this measure could go a long way in demonstrating the importance of healthy environments.
- In August the Special Interim Committee on Federal and State Affairs has stated a preference for local solutions.
- During the 2007 Legislative session, HB 2162 proposed a smoking ban in all school buildings and property. The bill was not heard in committee.

Stakeholder Input:

- Consumer Advisory Council supports a ban on smoking in public places.
- Purchaser Advisory Council believes all sectors of government should be involved in adoption of public policies to decrease tobacco use because health plans and insurers are not the only answer.
- Provider Advisory Council supports creating healthy workplaces.

The Kansas Hospital Association believes tobacco is the cause of death for 3,800 Kansans every year and is the root cause of many illnesses and lost productivity. Tobacco use in and around hospitals poses health and safety risks for patients, employees, and visitors. While Kansas currently has a statute banning smoking in medical care facilities, the Kansas Hospital Association would like to expand that ban to all hospital property.

Population Served:

- 1.4 million working adults in Kansas would benefit from working and living in a smoke free environment.

Costs:

There is no evidence of costs being incurred when smoking bans are put in place.

P2. Improve Healthy Behaviors for Families and Communities (3): Partnering with Community Organizations

Policy: Expand the volume of community-based wellness programs through partnerships between state agencies and community organizations.

Background:

Partnerships are key to developing effective community-based wellness programs. There are many examples of these types of successful partnerships throughout the state:

Partnerships with Local Health Departments. In 2004**,** KDHE, grants were awarded to 36 local health departments to promote physical activity initiatives within their communities. Additional training was later provided on using walking paths as catalysts to promote physical activity and better nutrition. Community grants such as these should be continually promoted across the state to provide needed funding for the construction of fitness centers, biking paths, and other wellness activities.

Partnerships with business groups. In 2004, KDHE and Mid-America Coalition on Healthcare (MACHC) collaborated to implement a pilot worksite wellness project in the Kansas City metropolitan area involving 14 large and medium-sized employers. The five-year project consists of four phases focusing on blood pressure, cholesterol, physical inactivity, obesity, poor nutrition, and tobacco use. The unique public-private partnership has engaged employers collaboratively with health plans, health care providers, universities, media, pharmaceutical companies, national researchers and various governmental agencies.

Partnerships with other state agencies. KDHE partnered with the KS Department of Commerce in 2006 to start a worksite Farmers Market in downtown Topeka to increase access to fresh, locally grown produce to downtown workers. This Market has continued into 2007with greater success. Similarly, the KHPA could partner with Kansas Department of Aging's (KDOA) successful STEPS program, farmer's market voucher initiative, and the Lifelong Communities program promoting successful aging among seniors.

Partnerships with faith communities. KDHE partners with the Center for Health and Wellness to provide community-based hypertension reduction activities in African American churches in Sedgwick County. The program targets undiagnosed cases of hypertension and refers those identified clients for treatment. Monthly blood pressure screenings are conducted in over 35 churches and senior centers. Other faith-based

partnerships in Kansas include the United Methodist Healthy Congregation program, providing technical assistance to United Methodist churches to develop a health plan for their congregations.

Population Served: All residents and visitors to the State of Kansas.

Costs: The exact cost of comprehensive, community based wellness programs across the states is not available. In FY 2005, 43 Kansas Counties shared over $ 400,000 in funding to enact population-based strategies to improve the health of the community, and to prevent premature deaths from heart disease, cancers, diabetes, and other chronic diseases. Risk factors addressed included tobacco use and exposure, physical activity, and nutrition. The exact costs of a partnership program will be dependent upon the expanse of the program and the scope of work.

Considerations: Kansas is in a unique position in that there are significant foundations within the state with a keen interest in health promotion. In addition to the UMMHM project mentioned above, both the Sunflower Foundation and the Kansas Health Foundation have recently supported community initiatives supporting enhanced physical activity and nutrition. This advantage gives Kansas the flexibility to adopt new and innovative strategies to promote health that are not confined by strict federal funding rules.

- Kansas can also benefit from the experience of other states. For example, the State of Vermont has developed a successful community engagement strategy aimed at promoting community infrastructure to support healthy lifestyles. Initiatives focus on the built environment (walking trials, bike paths, etc), physical activity programs in pilot communities, awarding grants to communities for programs and that support chronic disease prevention and management, and developing a toolkit for sharing successful evidence-based projects. There seems to be no reason that this process could not be replicated in Kansas.
- Support for additional organizations can improve health outcomes as the local level. For example, the Kansas Association of Counties (KAC) and the Kansas Association of Local Health Departments (KALHD) are seeking to improve birth outcomes through increasing access to early prenatal care through care coordination services and improved outreach efforts.

Stakeholder Input:
Advisory Council members commented on a variety of activities in their communities which were improving health behaviors, including:

- Distribution of pedometers and encouragement of walking
- Public health agencies teaching older adults on how to prepare healthier meals
- Chronic disease management program providing bathroom scales to local citizens

P2. Improve Healthy Behaviors in the Schools (1): Include Commissioner of Education on KHPA Board

Policy: Expand the KHPA board to include an ex-officio seat for the Kansas Commissioner of Education.

Description: Appoint the Kansas Education Commissioner as an ex-officio member of the KHPA Board.

Background: The KHPA Board is comprised of nine appointed voting members and six ex-officio members representing government agencies with critical roles in the promotion and development of health care policies, administration of health care programs and resources throughout Kansas. Inclusion of the education community in fulfilling this mission is essential to establishing a healthy future for our children. From an implementation perspective, the KHPA Board has the authority to implement this addition but should make known its intention known to the legislature due to the statutory origin of the KHPA.

Population Served: Kansas school children will be the greatest beneficiaries of a KHPA Board composition that recognizes the importance of health care policies that include the insight of the education community.

P2. Improve Healthy Behaviors in the Schools (2): Collect information on health/fitness of Kansas school children.

Policy: Support the establishment a state-based surveillance system to monitor trends of overweight, obesity, and fitness status on all public school-aged children in Kansas, as recommended by Governor's Council on Fitness.

Background: Obesity has become the second greatest threat to the long term health of children, second only to tobacco. The percentage of young people who are overweight has more than tripled since 1980. As a result, it is projected that one of every three children born in 2000 (and one of every two Hispanic children) will develop diabetes in their lifetime. By 2020, one of every four dollars spent on health care will be used for obesity-related treatments. The Governor's Council on Fitness recommends collection of body mass index (BMI) data and cardio-respiratory fitness data for all public school students in grades pre-K through 12. This data represents the first step in allowing us to assess and make informed decisions regarding the effectiveness of public health interventions and to assure that programs are reaching targeted populations.

Data on childhood obesity in Kansas is currently gathered through surveys. While the current method of self-reporting gives the state a subjective view of the issue, data is lacking on the demographics of the children most affected. The lack of information means that programs are unable to appropriately target the most vulnerable populations in a cost-effective manner.

Kansas-Specific Data:
K-CHAMP Data for 2004-2005 School Year:

- In the 2004-2005 school year, 32% of K-5th graders and 28% of 6-12th graders were either at risk for being overweight or were overweight.
- Seventeen percent of K-5th graders, 15% of 6-8th graders, and almost 12% of 9-12th graders were overweight.

Kaiser State Health Facts – Data Based on the National Survey of Children's Health:

- In 2003, 14% of Kansas children ages 10-17 were overweight.

YRBS Data:

- In Kansas, 14% of high school students were at risk for becoming overweight in 2007.
- Another 11% of high school students were overweight in 2007.

KSDE and KHI Study:

- More than 80% of public school and school district staffs support the collection of BMI.

Population Served:

- For the 2006-2007 school year, there were 465,135 Kansas school children enrolled in grades K-12

Costs: The schools would incur some indirect costs for staff training and completion of the BMI data collection and recording.

Considerations:

- Given the important role that education plays in improving the health and well-being of Kansas children, the KHPA Board should include the Commissioner of Education as a member.
- The Governor's Council on Fitness recommends a state-based surveillance system to monitor trends of weight and fitness status on all public school-aged children in Kansas. The Council recommends collection of body mass index (BMI) data and cardio-respiratory fitness data for all public school students in grades pre-K through 12.
- HB 2090 in the 2007 legislative session originally required BMI and fitness test measurement of Kansas schoolchildren (among other provisions). Despite modifications to the bill to the acquisition of limited BMI data only, it failed to pass out of the House Education Committee.
- Schools have expressed concern with loss of instructional time to perform the measurements, and with the time and fiscal costs of instituting such a program.
- One of the issues that arises with BMI measurement is what to do with the data. Programs in other states have floundered because of parental objections to "labeling" children as obese.
- This is an issue that KHPA can support, but is not within the current authority of the KHPA to regulate or enact. Nonetheless, in the larger perspective of advocating for the health of the state, it is appropriate for the Authority to express an opinion.

Stakeholder Input:

Advisory Councils:

Consumers:

- Support increased physical and nutritional education activities in schools
- All sectors of society should be involved in the adoption of public policies to decrease obesity and tobacco use with a focus on education
- Focus on prevention education for children, but also educate and empower parents
- Supports the notion of viewing health differently; as opposed to viewing health as the absence of disease the group prefers adopting policies that encourages Kansans to embrace behaviors that result in the highest level of individualized health potential

Providers:

- Acknowledge that the challenges of having healthy lifestyles for Kansans exist at all levels, regardless of age, education or income
- Interventions can be effective in improving health behaviors, based on successful experiences previously and currently implemented
- Support for policies that target children specific to obesity and tobacco use
- Focus prevention efforts on children and chronic disease management
- Support healthy schools

Purchasers:

- Acknowledgement of limited options for low-income individuals and an absence of accountability for Kansans overall when considering barriers that prevent Kansans from having health lifestyles
- All sectors of government should be involved in adoption of public policies to decrease obesity and tobacco use; health plans and insurers are not the only answer
- Focus on young children and chronic diseases
- Encourage community culture that creates safe places to live and play

P2. Improve Healthy Behaviors in the Schools (3): Promote Healthy Food Choices in Schools

Policy: Adopt policies that encourage Kansas school children to select healthy food choices in school by competitively pricing and marketing these foods and restricting access to foods with little or no nutritional value.

Background: Childhood obesity rates are climbing at an alarming pace. In Kansas, 14 percent of children aged 10-17 are overweight (Kaiser State Health Facts – Data based on the National Survey of Children's Health). Another 14 percent are at risk for becoming

overweight (YRBS Data). Measures should be taken to reverse this trend through the adoption of school policies that encourage healthy eating.

Many students have access to vending machines and a la carte menus that facilitate unhealthy food choices. In Kansas, 45 percent of school food service programs offer a la carte items. Over 90 percent of public high school students have access to vending machines. Some of the most common purchases are soda, chips, and candy. As greater emphasis is placed on individual responsibility in adopting healthy behaviors, consideration must be given to support children and provide an environment of making healthy food at school a priority.

Policy initiatives in schools are recommended that support implementation of the Kansas School Wellness Policy Model Guidelines for Nutrition. The guidelines provide recommendations to improve the nutritional quality of all foods and beverages available to students on school premises throughout the school day by addressing competitive pricing and promotion of healthy foods, portion size limitations, restricting access to foods of minimal nutritional value, all of which are effective strategies in reducing amount of soda consumed per week, increasing purchases of fruits, vegetables, and low-fat foods, and reducing overall energy intake.

Kansas-Specific Data:

KSDE and KHI Study:

- Almost 45% of schools' food service programs (K-12) offer a la carte items.
- Almost 59% of schools (K-12) who responded to the survey had vending machines available for use by students.
- Of the five most common items in vending machines available to students, three of them, carbonated beverages (# 1 available item with 89%), chips and other snack foods (# 4 available item with 74%), and candy (# 5 available item with 71%), could be considered "unhealthy."
- Some of the most frequently offered items in a la carte lunches included chips and snack foods at 71% and ice cream at 68% of a la carte lunches.
- Over 90% of public high school students had access to vending machines.
- Vending machines are more common in rural schools (78%) when compared to urban schools (55%). However, a la carte foods are more common in urban schools (65%) than in rural schools (30%).
- Among high schools, 86% allowed students to buy snack foods or beverages on the campus.

K-CHAMP Data for 2004-2005 School Year:

- While 87% of K-5th graders did NOT have access to vending machines, almost 69% of 6-8th graders and nearly 97% of 9-12th graders had access.
- Among 9-12th graders, 22% purchased regular soda, 9% purchased a salty snack that was not low fat, and almost 14% bought candy from a school vending machine.
- Over 17% of high school students and nearly 13% of middle school children reported having a diet high in fat over the last year.

- Less than 19% of K-5th graders, 22% of 6-8th graders, and 18% of 9-12th graders ate the recommended levels of 5 fruits and vegetables per day.

Population Served:

- For the 2006-2007 school year, there were 465,135 Kansas school children enrolled in grades K-12

Costs:

Implementation of competitive food restriction programs within Kansas schools will reduce the revenue generated by the sale of those food items.

Considerations:

- The issue of fiscal impact to schools is very real. School districts may utilize vending and other competitive food sales revenue to support extracurricular activities in the face of decreased funding from other sources. However, studies have generally demonstrated positive or neutral fiscal results when contents of school vending machines have been changed to provide more healthful choices.
- The Childhood Obesity Work Group (a subcommittee of the Governor's Council on Fitness and the Child Health Advisory Council) recommended in late 2006 that all competitive foods in schools be healthy and regulated. A portion of the intent is to make foods of minimal nutritional value unavailable to students during school hours.
- The 2007 Legislative session saw two bills introduced regarding vending machines in schools. HB 2275 proposed to limit student accessibility of vended foods and beverages in schools during school hours. SB170 addressed school beverage guidelines for students in elementary, middle schools and junior high school. Both were heard in committee.
- In 2006, HB 2870 was proposed and would have required that schools include a request for trans-fat information in all product specifications, beginning in 2007-2008. In 2009-2010, this bill would have directed schools to attempt to eliminate purchase of all products containing trans fat where practical.
- Also in 2006, HB 3016 was proposed and would have imposed a tax upon every distributor, manufacturer or wholesale dealer, to be calculated as 20 cents per gallon for each gallon of bottled soft drink sold or offered in the state. This bill would have exempted soft drinks containing more than 10% natural fruit juice or natural vegetable juice.

Stakeholder Input:

Advisory Councils:

Consumers:

- Support increased physical and nutritional education activities in schools
- All sectors of society should be involved in the adoption of public policies to decrease obesity and tobacco use with a focus on education
- Focus on prevention education for children, but also educate and empower parents

- Supports the notion of viewing health differently; as opposed to viewing health as the absence of disease the group prefers adopting policies that encourages Kansans to embrace behaviors that result in the highest level of individualized health potential

Providers:

- Acknowledge that the challenges of having healthy lifestyles for Kansans exist at all levels, regardless of age, education or income
- Interventions can be effective in improving health behaviors, based on successful experiences previously and currently implemented
- Support for policies that target children specific to obesity and tobacco use
- Focus prevention efforts on children and chronic disease management
- Support healthy schools

Purchasers:

- Acknowledgement of limited options for low-income individuals and an absence of accountability for Kansans overall when considering barriers that prevent Kansans from having health lifestyles
- All sectors of government should be involved in adoption of public policies to decrease obesity and tobacco use; health plans and insurers are not the only answer
- Focus on young children and chronic diseases
- Encourage community culture that creates safe places to live and play

Stakeholder Policy Positions:

Kansas Farm Bureau

- We support and encourage nutrition education and food handling/preparation training programs in Kansas schools. School food personnel should also receive nutrition education and food handling and preparation education.
- We strongly urge monitoring the use of federal funds for nutrition education in order to assure that students and food service personnel receive the benefits of such nutrition training programs.
- Health care is primarily the responsibility of the individual. Health care policy should embody the promotion of personal wellness, fitness and preventative care

Kansas Action for Children

- Create healthy school environments by limiting access to vending machines during the school day.

Considerations:

There would be a financial impact to schools that depend upon the profits generated through the sales of non-nutritional items to fund school programs and activities.

Paying for Prevention and Promoting Medical Homes

P2. Improve Healthy Behaviors in the Schools (3): Physical Education and School Health Programs

Policy: Strengthen Physical Education (PE) requirements and expand Coordinated School Health programs

Background: The Governor's Council on Fitness has developed a set of recommendations that calls for minimum physical activity and physical education requirements that are consistent with the Kansas Wellness Policy Builder developed by the Kansas Coordinated School health Program (KCSH). Collaboration is underway between KDHE and the Kansas Department of Education to implement an evidence-based Coordinated School health model that provides schools with a framework to address the health and wellness needs of their students and staff.

Some of the recommendations include a minimum of 100-150 minutes of physical education per week at the elementary and middle school levels, maintaining the current one unit requirement for high school graduation, and twenty minutes of recess for elementary students daily. In addition to requirements of students, the recommendations also emphasize the importance of physical education teachers who are specifically trained in the physical education field. Current law mandates physical education at the elementary level but only requires one credit unit total from middle through high school.

Kansas-Specific Data:

Kaiser State Health Facts – Data Based on the National Survey of Children's Health:

- In 2003, 14% of Kansas children ages 10-17 were overweight.

YRBS Data:

- In Kansas, 14% of high school students were at risk for becoming overweight (i.e., between 85th and 95th percentile for BMI, by age and sex) in 2007.
- Another 11% of high school students were overweight (95th percentile or above for BMI) in 2007.
- In 2005, the vast majority (around 72%) of high school students did NOT attend daily PE classes. This proportion increased in 2007 with around 74% NOT attending daily PE classes.
- Along with increases in those NOT attending PE classes on a daily bases, the percent of high school students not meeting recommended weekly physical activity levels increased dramatically. In 2005, just over 30% did not meet recommended levels; whereas in 2007, around 55% did not meet recommended levels.

K-CHAMP Data from 2004-2005 School Year:

- In Kansas, 39% of students in K-5 and 43% of 6-12th graders did not meet recommended levels of physical activity. As children age, the percent who meet recommended levels of physical activity decreases.
- Of Kansas students in K-5th grades, 77% were NOT enrolled in a daily PE class while 54% of 6-12th graders were NOT enrolled.

- During PE class, 27% of K-5th graders in Kansas did not exercise or play sports for 20 or more minutes compared to 11% of 6-12th graders.

Population Served:

- For the 2006-2007 school year, there were 465,135 Kansas school children enrolled in grades K-12

Costs:

The average cost to implement a Coordinated School Health planning process is $8,500 per school so the costs to schools would depend upon the number of schools participating in the program.

Considerations:

Coordinated School Health Program:

- Kansas Coordinated School health (KCSH) currently impacts 224 schools, which serve 80,736 students in 39 counties. Funding of $1,757,240 is being requested to implement a statewide comprehensive coordinated school health program.
- Schools are often concerned about taking away instructional time for physical education classes, especially in the context of the importance of standardized testing results. However, work is emerging that indicates that improved health and physical activity status of children translates into improvement in standardized test scores.
- Currently, 11 states mandate minutes per week for elementary schools, seven do so for middle/junior high schools, and ten do so for high schools. Among states that mandate minutes per week for elementary schools, only two (Louisiana and New Jersey) meet the national recommendation of 150 minutes or more per week (commonly "daily physical activity").

Current and Previous Regulations:

- In 2006, HR 6011 was enacted in signed by the Governor on March 10; this bill supports PE classes for all grades from K-12 and urges the State Board of Education to require some type of scheduled PE class for grades K-12.
- In 2007, HB 2090 proposed to require the collection of fitness data on students in grades 4, 7, 9 and 12 in order to benchmark the fitness of Kansas students and guide local and state policy makers. The bill was heard, but did not pass out of committee.

Stakeholder Input

Advisory Councils:

Consumers:

- Supports increased physical education activities in schools
- All sectors of society should be involved in the adoption of public policies to decrease obesity with a focus on education
- Focus on prevention education for children, but also educate and empower parents
- Supports the notion of viewing health differently; as opposed to viewing health as the absence of disease the group prefers adopting policies that encourages Kansans to embrace behaviors that result in the highest level of individualized health potential

Providers:

- Acknowledge that the challenges of having healthy lifestyles for Kansans exist at all levels, regardless of age, education or income
- Interventions can be effective in improving health behaviors, based on successful experiences previously and currently implemented
- Support for policies that target children specific to obesity
- Focus prevention efforts on children and chronic disease management
- Support healthy schools

Purchasers:

- Acknowledgement of limited options for low-income individuals and an absence of accountability for Kansans overall when considering barriers that prevent Kansans from having health lifestyles
- All sectors of government should be involved in adoption of public policies to decrease obesity; health plans and insurers are not the only answer
- Focus on young children and chronic diseases
- Encourage community culture that creates safe places to live and play

P2. Improve Healthy Behaviors in the Workplace (1): Develop Grant Program to Facilitate Wellness Initiatives in Small Businesses

Policy: Develop a community grant program to provide technical assistance and startup funds to small businesses to assist them in the development of workplace wellness programs.

Background: Large employers have frequently embraced workplace wellness programs as mechanisms to improve employee health, decrease absenteeism, and enhance productivity. The costs of starting such programs are prohibitive for small employers who often do not have adequate resources and economies of scale to pay for these kinds of programs. The component of "personal responsibility" within health care reform encompasses not only individual choice, but establishing an environment which facilitates the choice for health. Workplace wellness programs embody this strategy.

Well-designed worksite health interventions can have an enormous impact on disease prevention and control, resulting in significant savings in health care spending, improved presenteeism, and increased productivity. A comprehensive worksite wellness program consists of health education, supportive social and physical environments, integration of programs into the organizational structure, linkage to related programs such as employee assistance programs (EAP), and screening programs linking to health care. Comprehensive worksite health promotion programs can yield a $3 to $6 return on investment for every dollar spent over a 2–5 year period. Worksite health promotion programs can reduce absenteeism, health care and disability workers' compensation costs by more than 25% each.

Over 80% of businesses with over 50 employees have some form of health/wellness programs, but they are much less available in small businesses. Small businesses have limited resources and their lack of staff, budget, and wellness knowledge are barriers to providing wellness programs. Once established, however those wellness programs are quite economical costing $30-$200 per employee per year.

Kansas-Specific Data: Data from the U.S. 2000 Census detailing industry employment by size of industry documents the prevalence of small employers in Kansas. Of the 67,900 establishments with employees in Kansas, over 79 percent are in the under 100 employee size category. Business establishments (28,144) with 1 to 4 employees comprise 41.5 percent of the total, establishments (10,892) with 5 to 9 employees comprise 16 percent of the total, establishments with 10 to 19 employees (6,969) comprise 10.3 percent of the total, and businesses with 20 to 99 (7,833) employees comprise 11.5 percent of the total.

Population Served: Employees working for small Kansas firms.

Costs: $100,000 for pilot project to cover costs technical assistance and startup grants to small businesses.

Considerations:

- The Healthy Minnesota Workplace Initiative is in place to improve the health environment of workplaces in the state, raise awareness of and employee participation in workplace wellness programs, and expand workplace wellness programs. They have created a Workplace Wellness Toolkit and Web site for employers to use to implement worksite wellness programs and award mini-grants to workplaces to implement the Toolkit.
- KDHE has pilot tested the CDC's *Successful Business Strategies to Prevent Heart Disease and Stroke* toolkit as part of its Community Initiative on Cardiovascular Health (CICV), and has added and modified components of the toolkit in response to specific needs of the employers involved in the pilot. The toolkit addresses leadership support, employee attitudes, worksite environment, cardiovascular health plan benefit, and productivity measurement. Work is currently being completed on program intervention recommendations to address heart disease and stroke in the workplace. The program is poised to replicate the process among groups of employers in additional Kansas communities

Stakeholder Input:

Members of the Advisory Council supplied information about the success of wellness programs in small businesses. Several provided specific examples of effective strategies utilized at their workplaces.

Paying for Prevention and Promoting Medical Homes

P2. Improve Healthy Behaviors in the Workplace (2): Improve Food Choices in State Cafeterias and Vending Machines

Policy: Expand healthy food choices in state agency cafeterias and vending machines. State government has an opportunity to lead by example by providing greater in-house healthy food selections for employees.

Background: Obesity is a key contributor of many chronic diseases including some cancers, cardiovascular disease, and diabetes. Both nationally and locally, obesity rates have increased sharply in the past thirty years. According to the Centers for Disease Control and Prevention, the obesity rate among adults aged 20-74 increased from 15 percent of the population in 1976 to 33 percent of the population in 2003-2004. The estimated total cost of obesity in the United States as of 2000 was approximately $117 billion.

These statistics are even more sobering in Kansas. In 2006, over 36% of adults were overweight and nearly 26% were obese. Obesity has increased since 2000 when 21% of adult Kansans were obese. Promoting regular physical activity and healthy eating and creating an environment that supports these behaviors are essential to addressing the problem. Research shows that good nutrition can help to lower risk for many chronic diseases including heart disease, stroke, some cancers, diabetes, and osteoporosis. However, a large gap remains between healthy dietary patterns and what Americans actually eat. In 2005, only one-fourth of U.S. adults ate five or more servings of fruits and vegetables each day. In Kansas as of 2000, 23% of adults consumed 5 servings of fruits and vegetables per day. This proportion has since declined with less than 20% of adult Kansans meeting recommended levels of fruit and vegetable consumption in 2005. Providing more healthy food options in state cafeterias and vending machines at competitive prices might begin to reverse current trends.

Other states have utilized state government as a starting point for healthy eating options. One program is Arkansas' chronic disease plan in which approximately 10,000 state employees completed the Healthy Employees Lifestyle Program (HELP) pilot. The Arkansas Department of Health provides nutrition related information to its vendors in order to promote stocking vending machines with healthier options. They also have a worksite wellness program "Fit with 5" that encourages workers to get the recommended levels of physical activity of 30 minutes on five or more days of the week and to eat five fruits and vegetables every day.

Kansas-Specific Data:
*BRFSS Prevalence Data for Kansas (*http://apps.nccd.cdc.gov/brfss/):

- In 2006, over 36% of adults were overweight and nearly 26% were obese. Obesity has increased since 2000 from less than 21% of adult Kansans who were obese.
- In 2000, 23% of adults consumed 5 servings of fruits and vegetables per day. This proportion has since declined with less than 20% of adult Kansans meeting recommended levels of fruit and vegetable consumption in 2005.

Landon State Office Building Data:

- State cafeterias commonly serve foods high in fat and sugar, and overall high in calories. In addition, many of the healthier items are more expensive than the "non-healthy" items (e.g., A chef salad cost $3.75, whereas a hamburger cost $2.75 and French fries cost $1.25). Here is an example of the menu from the cafeteria at the Landon State Office Building ("healthy items are bolded):
    - Breakfast:
        - Sausage/Bacon/Ham and Egg Sandwich (can add cheese)
        - French Toast
        - Biscuits & Gravy (small or large)
        - Sides: Biscuits, muffins, cinnamon rolls, **yogurt**, **boiled egg**
    - Lunch
        - Taco Salad
        - Hamburger, Taco Burger, Sancho
        - French Fries
        - Chicken Fried Steak
        - **Sub Club**
        - Grilled Cheese, Grilled Ham & Cheese Sandwich
        - **Chef Salad (can add chicken)**
        - Sample Lunch Menu: Meatloaf, mashed potatoes & gravy, **vegetable side item,** dinner roll, and a drink **(can substitute extra vegetables for the mashed potatoes)**
    - Other Items
        - Large bag of potato chips
        - Candy bars
        - **Nuts, Sunflower seeds**
        - Muffins, pastries
        - **Yogurt, Fruit cups, Fresh fruit, Cottage cheese**
        - Soda, **Milk, Juice, V8, Coffee, Tea, Water**, Hot Chocolate, Cappuccino
- Vending machines also provide high fat/sugar food options; here is an example of the contents from one vending machine in LSOB:
    - Chips (7 varieties; only 1 baked option)
    - Pretzels (2 of the 3 options were chocolate covered)
    - Cookies (7 options)
    - Peanuts (1 option), Sunflower seeds (1 option)
    - Candy Bars (8 options)
    - Pastries (2 options)

Population Served:

- On Oct. 5, 2007 there were 38,130 full-time and 3,416 part-time employees (total of 41,546).
- Other populations impacted would include contract workers and employee guests who frequently visit state agency facilities.

Stakeholder Input: Various organizations, such as the Kansas Medical Society, the Kansas Association for Health Underwriters, and the Kansas Farmers Bureau (KFB), have public positions which encourage Kansans to live healthy lifestyles to extend their productive lives and reduce the demand for expensive health care.

Advisory Councils:

Consumers:

- All sectors of society should be involved in the adoption of public policies to decrease obesity with a focus on education
- Supports the notion of viewing health differently; as opposed to viewing health as the absence of disease the group prefers adopting policies that encourages Kansans to embrace behaviors that result in the highest level of individualized health potential.

P2. Additional Prevention Options (1): Inclusion of Dental Coverage for Pregnant Medicaid Beneficiaries

Policy: Include coverage of dental health services for pregnant women in the Kansas Medicaid program.

Background: Recent studies continue to show that poor oral health has an effect on overall systemic health. One of the most convincing links is between oral infections and poor birth outcomes, specifically low birth weight babies. Providing dental benefits for pregnant women may help reduce this problem.

Kansas Medicaid pays for roughly 40% of births in Kansas. Efforts have been made with Head Start, WIC and in local health programs to educate women on the importance of good oral health during pregnancy, but without dental coverage, pregnant women are without resources to pay for oral health care. Recent evidence based studies have shown a relationship between periodontal disease and premature births and cardiac disease. Avoidance of even one premature birth can save the State from future years of medical services and disability payments.

Currently Kansas Medicaid coverage only provides emergency dental coverage (mainly tooth extractions) for most adults on Medicaid, including pregnant women. Providing a complete dental benefit for pregnant women on Medicaid in Kansas, will allow them to receive routine cleanings, fillings, and periodontal (gum disease) treatment. This type of treatment will prevent oral health emergencies and oral infections during pregnancy in many women.

Population Served: Pregnant women enrolled in Medicaid.

Cost Estimate: $500,000 SGF for provision of dental benefits to 6,600 pregnant Medicaid enrollees.

Considerations:

- Kansas pays the costs of several "million dollar" premature babies a year. The March of dimes reports that an average premature birth costs as much as $500,000 over the lifetime of a child. The costs savings of preventing just a few of these births would easily cover the cost of the benefit.
- Providing additional Medicaid dental funding would support the community health clinics or "dental hubs" as they would receive compensation for treating these previously uninsured patients. The Kansas Legislature has appropriated $2 million in new money for the state's primary care safety net clinics in fiscal year 2008. It includes $500,000 earmarked for developing access to oral health care through dental "hubs."
- Enrollment of dentists in the Kansas Medicaid has improved since the State changed from a capitated managed care plan to fee for service. However, when discussing increasing dental benefits for Medicaid beneficiaries, there is concern about the lack of capacity of dental Medicaid providers and low dental reimbursement rates. Oral Health Kansas and the Kansas Dental Association are also preparing cost estimates to increase dental reimbursement rates to help provider enrollment.

Stakeholder Input:

- Oral Health Kansas, the Kansas Dental Association, and the KAMU will asking the legislature this year for a full adult dental benefit for all Medicaid beneficiaries. In the last two years, the legislature has expanded funding for disabled adults in waiver programs, but that still leaves approximately 75,500 enrollees without dental coverage. If they are successful in funding a full adult benefit, pregnant women will have dental coverage.
- Members from the Consumer and Provider Advisory Councils discussed how they believed health benefit designs should include dental care coverage, especially for preventive services.

P2. Additional Prevention Options (2): Provide Tobacco Cessation Support for Medicaid Beneficiaries

Policy: Improve access to tobacco cessation programs (over-the-counter, prescription medication and counseling) in the Kansas Medicaid program in order to reduce tobacco use, improve health outcomes, and decrease health care costs.

Background: According to the 2004 National Health Interview Survey, approximately 29% of adult Medicaid beneficiaries were current smokers. This figure was higher than the 2005 estimated rate of 20.6% for current smoking among the general population. The smoking rate for adults in Kansas is approximately 17.8%, and national data suggests the rate for Kansas Medicaid beneficiaries is higher than that of the general state population. (http://www.statehealthfacts.org).

In order to decrease smoking rates, the 2000 Public Health Service clinical practice guidelines recommended tobacco-dependence treatment which included medication and counseling. One of the 2010 national health objectives is to increase insurance coverage

of evidence-based treatments for tobacco dependence among all 51 Medicaid programs. Kansas Medicaid currently provides reimbursement for some pharmaceuticals products to treat smoking cessation, however, the state does not reimburse for counseling for smoking cessation. This proposal would expand reimbursement for smoking cessation treatment to include counseling in an individual and or group setting. The expansion would be consistent with the changes occurring within the State Employee Health Plan which will include coverage of pharmaceuticals as well as specific smoking cessation programs.

Kansas-Specific Data:

- 49 percent of Kansas adult smokers attempted to quit and failed in 2004 compared to 55 percent nation wide (Kaiser Foundation, statehealthfacts.org).
- The annual average of smoking attributable deaths in Kansas is 3,900 (CDC, Sustaining State Programs for Tobacco Control Data Highlights, 2006).
- 28.6 percent of the adult smokers in Kansas have an income of less than $15,000.
- In Kansas, smoking-attributed costs for Medicaid reached $196 million in 2004 (CDC Sustaining State Programs for Tobacco Control Data Highlights, 2006).
- Kansas Medicaid covers the medication Chantix for up to 24 weeks in a year.
- Kansas Medicaid does not cover the following medications: Zyban, Gum's, Patch, Inhaler, Nasal Spray
- Kansas Medicaid does not cover group, individual, or telephone counseling.

Population Served: The approximate 83,200 Kansas Medicaid beneficiaries who smoke would benefit from the increased coverage of tobacco cessation, improving health and lowering health care costs. The Kansas population overall would benefit from a less prevalent smoking environment.

Costs: To provide coverage for a counseling session and over the counter drugs for tobacco cessation would cost approximately $500,000 annually.

The Medicare rate for a 10 minute counseling session as part of physician office visit and referral is $11.61. During FY 2007, 10,778 beneficiaries received $2.1 million worth of tobacco cessation pharmaceuticals. The Centers for Disease Control (1999) reported that 10.0 percent of smokers aged 18 years and older use the full amount of available cessation services to quit smoking. We assume that the current beneficiaries receiving Medicaid funded drugs would take advantage of the additional counseling services and an additional 32,000 beneficiaries, or half of all Medicaid smokers, would seek treatment to stop smoking.

Considerations:

- The prevalence of smoking is 50 percent greater in the Medicaid population than in the general population. (National Conference of State Legislatures, 2004).
- According to the 2004 National Health Interview Survey approximately 29 percent of adult Medicaid beneficiaries were current smokers.
- It has been estimated the annual Medicaid program costs caused by smoking are more than $23billion. (National Conference of State Legislatures, 2004).

Stakeholder Input:

- Consumer Advisory Council believes health benefit designs should reflect life-style behaviors to incentivize and reward health.
- Provider Advisory Council recognizes that changes to be included in health benefit designs to incentivize and reward health need to address both the current health care delivery system and individual behaviors.
- Purchaser Advisory Council believes all sectors of government should be involved in adoption of public policies to decrease tobacco use because health plans and insurers are not the only answer.

P2. Additional Prevention Options (3): Improve Access to Cancer Screening

Policy: Increased screenings for breast, cervical, prostate, and colon cancer through expansion of the Early Detection Works (EDW) Program.

Background:

One of the most significant ways of improving health and decreasing health care costs is to remove barriers to preventive care. Screenings are an effective way to identify those at risk of future disease, or to unmask the disease itself while still in the earliest stages of development. Disease caught early leads to improved efficacy of treatment and decreased long-term morbidity, mortality, and health care costs.

Breast and Cervical Cancer - Studies show that many deaths from breast and cervical cancers that result disproportionately in death among women who are uninsured or underinsured could be significantly reduced by increasing screening rates among at risk women. Timely mammography screening among women 40 or older may prevent 15% to 30% of all deaths from breast cancer. In Kansas, nearly 400 women die of breast cancer every year, yet access to timely screening could prevent between 60 and 120 of those deaths. If detected early, the survival rate is 90 percent. The survival rate plummets to 20 percent when detection is late. Similarly, cervical cytology or pap smears results in detection and treatment of precancerous lesions and cervical cancer at an early stage. In the last five years, an average of thirty-five women have died annually. Approximately 50% of those deaths would be prevented with adequate screening.

The Early Detection Works (EDW) Program is funded by a cooperative agreement between the Centers for Disease Control and Prevention (CDC) and KDHE. The program helps low-income, uninsured, and underserved women between the ages of 40 and 64 gain access to lifesaving early detection screening services for breast and cervical cancers. The Early Detection Works Program served 7,200 women in FY2006 and an estimated 6,200 Kansas women in FY07. These results are encouraging but the need is significant. Over 27,000 women may qualify for EDW services in Kansas.

Prostate Cancer - Prostate cancer is the most common cancer diagnosed in men. More than 1,800 cases are annually diagnosed in Kansas, and 250 men die from prostate cancer

each year. Screening for patients at high risk of prostate cancer based on race, age, lifestyle, and family history will result in greatly increased survival rates. While prostate cancer occurs more frequently at age 50, screening should begin at age 40 for those who are at high risk. Based on income, lack of insurance and age, it is estimated that 21,000 men would qualify for prostate cancer screening.

Colorectal Cancer - Colorectal cancer usually develops from precancerous polyps in the colon or rectum. Screening tests detect precancerous polyps so that they can be removed before becoming cancerous. Screening can also detect colorectal cancer early, when treatment is most effective. Screening should occur for all persons over age fifty. In Kansas, an average of 550 persons died each year of colorectal cancer. The CDC indicates that routine screening for colorectal cancer can reduce this number by at least 60%.

Population Served: All three programs are targeted to those at high clinical risk but lacking the income and insurance resources to access screenings. Expansion of the EDW program at the cost indicated below may allow a total of approximately 7,500 women to be served, which is an increase of 1,700 over the current service population. Funding of a prostate cancer screening program is estimated to serve just over 6,100 men at risk. The colorectal cancer screening effort may provide care for over 12,000 Kansans.

Cost Estimate: The total cost estimate of the combined programs is $6.2 million dollars for SFY 2009 is estimated as follows:

Colorectal Cancer Screening and Diagnostic services = $3,668,125
Prostate Cancer Screening and Diagnostics = $1,213,360
Breast and Cervical Cancer Screening and Diagnostics = $1,141,529

Considerations:

- The expense of cancer screening is often raised as a concern. While short-term costs for screening and treatment may rise to a small degree, the long-term savings resulting from treating cancer in its early stages as opposed to costly treatment that accompanies advanced cases will provide for greater cost savings overall.

- The cost of these screening recommendations pertains only to data addressing need in SFY 2009. Changes in health care programs, including potential expansions of Medicaid and Premium Assistance programs may alter funding needs and eligibility levels in future budget cycles.

Providing and Protecting Affordable Health Insurance (P3)

Providing and Protecting Affordable Health Insurance: Background Information

One of the three KHPA goals for health reform in Kansas is providing and protecting affordable health insurance. Underlying this goal is the need for all Kansas to have access to affordable health insurance in order to reduce barriers to receiving appropriate, adequate, and timely health care services.

Background on Health Insurance in the United States[6]:

Employers, both private and public, are the primary source of health insurance for people under age 65 (Medicare covers most of the elderly). Some 160 million U.S. workers and their dependents receive health benefits through the workplace. But in recent years, good, comprehensive coverage has been harder to come by. Although annual growth in national health care expenditures and premiums has leveled off at around 7 percent, it continues to outpace economic and wage growth by a wide margin. As a result, employers who provide health benefits—especially small firms—are finding it difficult to maintain their level of generosity. Businesses have tried to cope by sharing more of their expenses with employees, but some small companies have eliminated health benefits altogether. Nearly the entire increase in the number of uninsured Americans between 2000 and 2006—to 44.8 million—is attributable to the decline in employer coverage.

Background on Health Insurance in Kansas[7,8,9]:

In Kansas, approximately 11 percent of the population, or nearly 300,000 people, are uninsured. Misconceptions about the uninsured are very common; for example, some believe that individuals who lack health insurance are unemployed. On the contrary, 95 percent of uninsured Kansans live in a household with at least one worker. Individuals most at-risk for lacking health insurance include young adults, individuals employed by small businesses, racial and ethnic minorities, low-income individuals, and residents of Southwest Kansas.

Compared to other groups, young adults ages 18-34 have higher uninsured rates. Around 57 percent of individuals ages 18-34 are uninsured compared to 10 percent of Kansans ages 35-64. Another at-risk group, employees of small businesses, is disproportionately represented among the uninsured. Over 77 percent of the uninsured work for small businesses with 50 or fewer employees. Many small business employers are unable to or choose not to offer health insurance as an employee benefit.

Among racial and ethnic minorities Hispanics are more frequently lacking health insurance. Nearly 30 percent of Hispanics versus 9 percent of non-Hispanic whites in Kansas were uninsured for 2004-2005. In addition, Non-Hispanic Blacks are 1.5 times

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[6] Excerpts from the Common Wealth Fund website for the Program on the Future of Health Insurance. Available at http://www.commonwealthfund.org/programs/programs_list.htm?attrib_id=11934.
[7] Kansas Department of Insurance. Excerpts from the State Planning Grant Findings for 2001. Other reference materials located at http://www.ksinsurance.org/.
[8] Kansas health insurance statistics were collected from the Annual Social and Economic Supplement to the Current Population Survey available at http://www.bls.census.gov/cps/asec/adsmain.htm.
[9] Excerpts from the Mercer Uninsured Report: State of Kansas. July 7, 2005.

more likely to be uninsured than non-Hispanic whites with almost 15 percent uninsured during that same time period.

Income level is another predictor for being uninsured. Low-income individuals are more likely to be uninsured than higher income individuals. For individuals with annual family incomes of less than $25,000, 22 percent were uninsured with another 13 percent uninsured for those with family incomes between $25,000 and $50,000.

Geographical location is a determinant of health insurance status; nearly 17 percent of Kansans living in the southwest are uninsured. Of the eight counties in Kansas with uninsurance rates at or above 18 percent, six of them are located in the southwest region. One explanation is due to this region having the largest proportion of Hispanics, whom as discussed above, have the highest percent of its population uninsured.

Kansas faces challenges in terms of health insurance availability and affordability, particularly for small employers. Over two-thirds of uninsured full time working adults in Kansas are employed by firms with less than 25 employees. For more than a decade the number of uninsured Kansans has remained static hovering around eleven percent and past insurance reforms have had minimal impact on improving access to health insurance in Kansas. The state has undertaken a number of incremental policy actions to improve access to health insurance for other sub-populations of Kansans. Health insurance policies enacted in Kansas aimed at improving small employer access to health insurance include guaranteed access by small employers to all insurance plans offered by carriers and the establishment of premium rating bands. To address access problems of those in the individual market denied health insurance due to existing health problems, the legislature established a "high-risk" pool, but a limited number of persons have used this mechanism due to the premium costs.

Increasingly Kansans in various venues are expressing growing concern about their continued access to affordable health insurance. A September 2003 poll of Kansas residents' views of the health care system commissioned by the Kansas Health Institute and conducted by Harvard School of Public Health, found that seventy-eight percent of Kansans felt that funding programs that help small businesses find affordable health insurance was an extremely or very important priority for the state's health care agenda. And when asked if cost, quality or access was the most important health care issue at the present time, 38 percent of Kansans felt that access to health care was the most important, compared to 48 percent for cost and 9 percent for quality. A 2004 survey of small business' health insurance experience revealed increasing vulnerability in continued provision of health insurance to employees. Kansas employers participating in the 2004 Small Business Health Insurance Survey reported that insurance premiums had increased substantially from 2003 to 2004 with over thirty percent of firms reporting that their premiums rose by 16-25 percent and 28 percent reporting that their premiums rose over 25 percent. More than a fifth of the firms reported that they were considering dropping coverage and nearly three-fifths were planning to increase employee contributions.

Policy Options: The three components of the updated Sequential Model policy options designed to provide and protect affordable health insurance for all Kansans are described in more detail in the presentation by the SchrammRaleigh LLC Consultants:

- (1) Expanding insurance for low-income Kansans
- (2) Access to care for Kansas children
- (3) Affordable coverage for small business